

Accountability for Change: Solution-Focused Treatment With Domestic Violence Offenders

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ABSTRACT

In this article, the authors discuss and evaluate a solution-focused treatment program for domestic violence offenders. Building on a strengths perspective, a solution-focused approach holds a person accountable for solutions instead of focusing on problems. The outcome study was a 1-group pre- and posttest design with a 6-month follow-up to evaluate the effectiveness of a solution-focused group treatment program for 90 domestic violence offenders who were ordered by the court to receive treatment. Findings of the outcome study indicated a recidivism rate of 16.7% of program participants as based on official records over a 6-year period. There was a significant improvement in participants' relational skills in intimate relationships as evaluated by their spouses or partners and a significant increase in their self-esteem based on self-reports. Implications for treatment and research with domestic violence offenders are discussed.

Diverse responses have been instigated by society in an attempt to end domestic violence in intimate relationships that has plagued society and deeply hurt families and children. The early efforts of the battered women's movement in the 1970s to protect the victims and their children have been expanded to include legal sanction of domestic violence as well as provision of treatment for offenders (Roberts & Swanger, 2002; Schechter, 1982). Treatment programs for domestic violence offenders began as men's voluntary responses to the battered women's movement in an attempt to confront men's violence against women as a result of patriarchal beliefs. The first batterer program, EMERGE, was established in 1977 at the request of women working in Boston area shelters (Schechter, 1982). Currently, these treatment programs are incorporat-

ed as an integral part of the coordinated system response to domestic violence in which the courts routinely send domestic violence offenders to receive group treatment while on probation as an alternative to serving sentences. Despite the proliferation of batterer programs across the country, the search for effective treatment models that assist offenders to live a life free of violence presents a constant challenge for service providers.

Currently, the design of most treatment programs for domestic violence offenders is based on a cognitive-behavioral approach that mainly targets individual characteristics or problems contributing to violent behaviors (e.g., Geffner & Mantooth, 1999; Saunders, 1996) and/or a feminist perspective that focuses on the sociocultural roots of domestic violence (e.g., Martin, 1976; Pence & Paymar, 1993; Walker,

2000). Such treatment designs are influenced by the predominance of individual and sociocultural factors in understanding the etiology of domestic violence. Proponents of the individual pathology perspective usually take a mental health perspective; offenders have mental health, substance abuse, and/or personality issues that must be addressed in order to stop violent behavior (e.g., Dutton, 1995; Gondolf & White, 2001; Holtzworth-Munroe & Stuart, 1994; Kantor & Straus, 1987). The feminist perspective focuses on sociocultural factors and maintains that male dominance and misogyny that are based on patriarchal beliefs and social structure constitute the root of violence against women. The goals of profeminist treatment programs are to raise offenders' consciousness about sex role conditioning, to resocialize men to work toward equality for women, and to take responsibility for their abusive behavior (Mederos, 1999; Pence & Paymar, 1993). These treatment approaches usually take a deficits perspective and assume that domestic violence offenders have deficits in knowledge and/or skills that are necessary for avoiding battering (Geffner & Mantooth, 1999). Building on such assumptions is a treatment orientation whose practitioners believe that the behaviors of domestic violence offenders can be and need to be changed through a reeducation process. Consequently, the core components of these treatment programs generally include direct education about violence, anger management, conflict containment, communication training, stress management (Geffner & Mantooth, 1999; Russell, 1995), and raising awareness of patriarchal power and control (Pence & Paymar, 1993). The resulting psychoeducational programs usually focus on challenging participants to recognize and admit to their violent behaviors, to take full responsibility for their problems (Lindsey, McBride, & Platt, 1993; Pence & Paymar, 1993; Russell, 1995), to learn new ways to manage their anger, and to communicate effectively with their spouses (Geffner & Mantooth, 1999; Sonkin, 1995; Wexler, 1999).

The significant contributions of feminist-cognitive-behavioral treatment approaches in the advancement of treatment for domestic violence offenders can never be overestimated. On the other hand, questions have been raised regarding the effectiveness of such programs, both from a clinical and an outcome perspective. A major therapeutic hurdle when working with this population is the issue of motivation (De Jong & Berg, 1999). Client-treatment congruence is a significant

factor associated with treatment compliance and hence treatment effectiveness. Client-treatment congruence refers to the extent to which clients' assessment of their own problems matches their perception of the potential benefits of the specific treatment they are receiving (Wierzbicki & Pekarik, 1993). Most domestic violence offenders are involuntary clients who are ordered by a court or forced by their partners to receive treatment. Their perceptions of problems are often-times not the same as the perceptions of their referral sources or service providers. A focus on challenging participants to recognize and admit to their violent behaviors, to take full responsibility for their problems, to learn new ways to manage their anger, and to communicate effectively with their spouses is a theoretically sound approach informed by cognitive-behavioral theories and feminist perspectives, although such approaches may not be a good match with clients' perception of their problems.

A mismatch between offenders' perceptions of problems and the treatment provided is often-times manifested in constant evasiveness, silence, phony agreement, or vociferous counterarguments when participants are confronted with their problems of violence (Murphy & Baxter, 1997). Many of them stop attending the program altogether, resulting in serious attribution problems for batterer

Therapeutic dialogues focus on a range of evaluative questions that assist participants in self-evaluating the usefulness, appropriateness, and feasibility of their goals in their personal lives.

programs. Program noncompletion rates have been high in both short-term and long-term treatment programs. Approximately 60% of men attending the first session of short-term batterer programs (usually 10–20 weeks) completed the program; program completion was usually defined as missing no more than 2 to 4 sessions (Cadsky, Hanson, Crawford, & Lalonde, 1996; Chang & Saunders, 2002; DeMaris, 1989; Edleson & Syers, 1990). These programs are mostly based on feminist-cognitive-behavioral or process-psychodynamic models. Attribution problems appear to be more serious for long-term programs. Men in 32-session batterer treatment programs had higher program noncompletion rates than men in the 12-session programs (Edleson & Syers, 1990). Gondolf and Foster (1991) studied the attribution rates of a 32-session batter program. Of the 27 participants who attended the first session, only 7.4% completed 32 sessions. The widespread use of court-mandated treatment in combating domestic violence may be effective in getting offenders into treatment, although the effectiveness of court mandates for ensuring treatment attendance is inconclusive as court-mandated clients drop out at similar or even higher rates than do voluntary clients (Cadsky et al., 1996; Saunders & Parker, 1989).

In addition, some professionals have begun to raise doubts about how a focus on confrontation and deficits can be conducive to stopping violence or initiating positive changes in offenders (Edleson, 1996; Uken & Sebold, 1996). Because blaming is one of the major strategies used by offenders to intimidate victims and to justify their abusive acts, using confrontation and assigning blame in treatment may re-represent a similar and nonhelpful dynamic in abusive relationships. The effectiveness of a deficit perspective and/or a blaming stance in treatment is dubious if one looks at the characteristics of domestic violence offenders. The most consistent risk markers for violent males have been identified as experiencing and/or witnessing parental violence, frequent alcohol use, low assertiveness, and low self-esteem (Hotaling & Sugarman, 1986; Saunders, 1995; Straus, 1996). As a result, a high percentage of domestic violence offenders are likely to be insecure individuals at the margins of society who victimize others to boost their low self-esteem. Studies on personality further indicate that many domestic violence offenders fit the personality profile of narcissistic or borderline personality disorder (Dutton, 1995; Hamberger & Hastings, 1990). It is well-documented that persons who are narcissistic or borderline have a very fragile sense of self and do not, in general, respond well to confrontation and criticism (Kernis & Sun, 1994); such individuals may perceive and experience instruction and skill training as criticism and rejection.

Findings of empirical studies of the effectiveness of current treatment programs are not conclusive. Reviews of domestic violence offender treatment programs generally report recidivism rates ranging from 20% to 50% in the year after the completion of program (e.g., Edleson, 1996; Rosenfeld, 1992; Tolman & Edleson, 1995). The recidivism rate of the Duluth Domestic Abuse Intervention Program, on which the Duluth model was developed, was 40% (Shepard, 1992). The Duluth model is the most widely used approach for treating domestic violence offenders that adopts a feminist-cognitive-behavioral perspective. Saunders (1996) also reported a recidivism rate of 45.9% for the feminist-cognitive-behavioral treatment models. Two recent experimental evaluations have found batterer treatment programs to be largely ineffective in that there were no significant differences between those who received group treatment and those who did not in terms of their attitudes, beliefs, and behaviors (Feder & Forde, 2000) or in terms of victims' reports of new violent incidents (Davis, Taylor, & Maxwell, 2000).

Hanson (2002) suggested that the field of treatment of domestic violence offenders is political as well as empirical. Berger and Luckmann (1966) wrote, "One does certain things not because they work, but because they are right—right, that is, in terms of the ultimate definitions of reality promulgated by the ... experts" (p. 118). The inconclusive research and practice evaluations, on the other hand, can be an invitation for service providers to revisit the existing paradigm of treatment for domestic violence offenders.

Solution-Focused Treatment of Domestic Violence Offenders

The Plumas Project is a solution-based, goal-directed domestic violence group treatment program co-led by a female and male therapist. Inspired by the work of Insoo Kim Berg, Steve de Shazer, and their associates at the Brief Family Therapy Center in Milwaukee (Berg & Kelly, 2000; de Shazer, 1991), the facilitators of the program use a treatment approach that holds domestic violence offenders accountable for solutions rather than responsible for problems. The treatment model is an accumulation of practice experience, wisdom, and learning from errors since 1991. Building on a strengths perspective and using a time-limited approach, solution-focused treatment for domestic violence offenders postulates that positive and long-lasting change can occur in a relatively brief period of time by focusing on solution talk instead of problem talk. Focusing on and emphasizing solutions, competencies, and strengths in offenders must never be equated with a minimization of the destructiveness of their violent behaviors. A solution-focused group treatment model does not deny or minimize aggressive and/or violent behaviors. Similar to other treatment programs, such an approach recognizes the role of offenders in instigating violence against the victims; it also recognizes that treatment programs are a part of the coordinated community response to domestic violence. In addition, the effectiveness of a solution-focused treatment program is contingent on the support of the legal system that provides a strong sanction against violent behaviors. Different from the feminist-cognitive-behavioral approaches, however, a solution-focused approach uses the language and symbols of solution and strengths and does not go into the history of the problem in the treatment process. Although it is not feasible to go into the details of the treatment program that have been described elsewhere (Lee, Sebold, & Uken, 2003b), it is important, however, to briefly describe the program as well as its guiding principles because solution-focused treatment is still a relatively new orientation for working with domestic violence offenders.

The Treatment Model

Treatment includes eight 1-hour group sessions over a 3-month period. Program participants include both male and female offenders. The solution-building process begins with the intake process when the facilitator asks specific questions related to client strengths, such as the following: "What are some of your recent successes? What have you done that you are proud of? What have you done that took a lot of hard work? Have you ever broken a habit that was hard to break? What kinds of things do people compliment you on?" These questions give the potential participant and the facilitator an opportunity to begin assessing potential strengths and resources in offenders. There is no exploration of the history of the problem of violence at intake or during treatment.

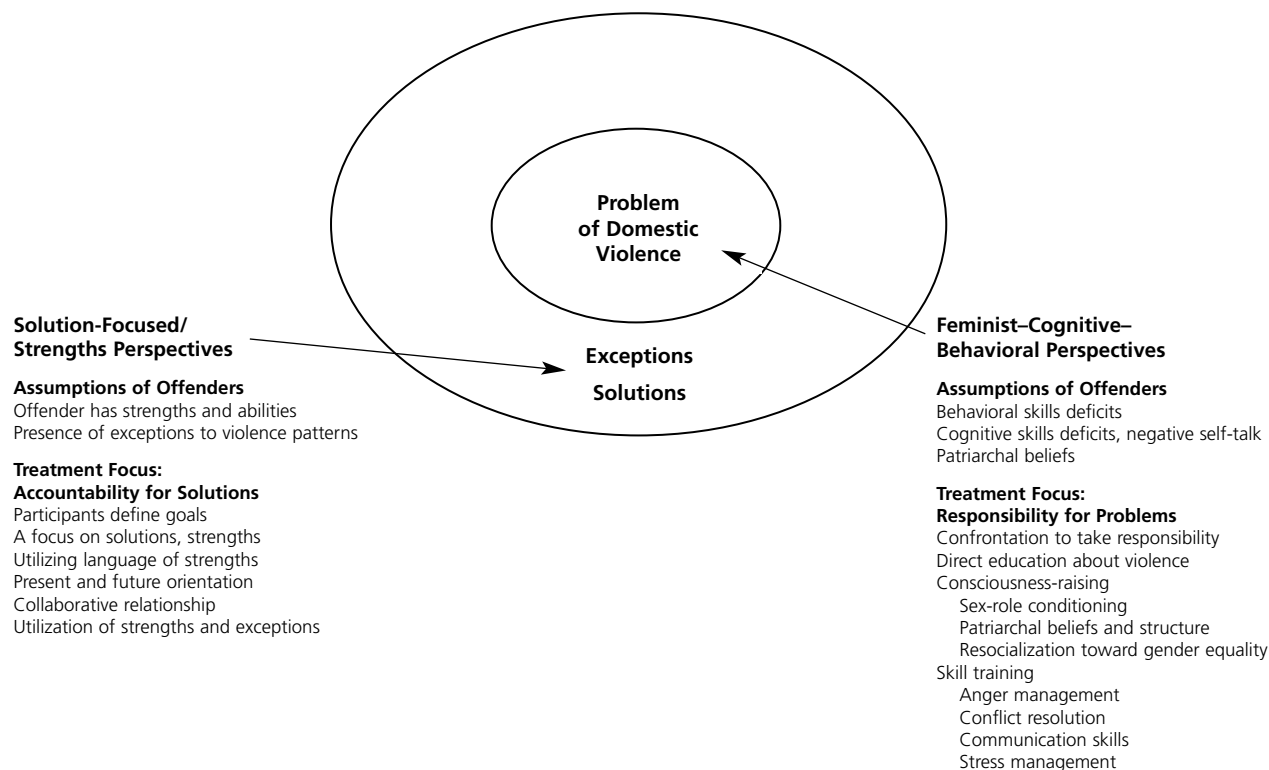
We also do not screen and/or exclude potential participants on the basis of the severity of violence, substance use, or diagnoses based on the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). From a solution-focused perspective, facilitators are more interested in assessing the observable surface behaviors of individual participants that are relevant in their search for and accomplishment of personally meaningful goals than in using diagnoses for determining treatment (de Shazer, 1994). Traditional diagnostic approaches tend to focus on problem categories that revolve around a person's deficits. Labeling can inadvertently sustain a problem reality in that the facilitator begins to make assumptions based on a diagnosis rather than on the broader reality that reflects who the person is and what the individual is capable of (Berg & Miller, 1992). Because participants have problems with violence, it is also important to help potential participants assess their ability to cooperate, develop solutions, and manage their anger and frustrations in the treatment process.

The program utilizes a goal to create a context for participants to identify, notice, rediscover, and reconnect with their strengths and resources. Participants are required to develop a personally meaningful goal that is interpersonally related, can be practiced on a regular basis, and is a new behavior for them (Lee et al., 2003b). They are required to share their goal efforts in each session. Because participants developed and

determined their personal goals, the goals chosen by individual participants were as diverse as they themselves. Three major themes of goals were goals focusing on self (e.g., controlling anger, increasing self-confidence, etc.), goals focusing on relationships (e.g., listening to spouses or partners, being aware of other's needs, being nice, spending more time with family members, giving space to self and others, etc.), and goals focusing on developing helpful attitudes (e.g., staying positive, staying focused on goals, taking responsibility, accepting others, being relaxed, being open and flexible, etc.; Lee, Sebold, & Uken, 2003a). Therapeutic interventions revolved around assisting participants to develop useful and well-formed goals; utilizing goal accomplishment to expand, amplify, and reinforce solution behaviors in a real-life context; and consolidating new descriptions of self that do not contain violence (see Lee et al., 2003b, for a detailed description of the program). In addition, we addressed therapists as facilitators and the domestic violence offenders as participants. The major tasks and functions of facilitators are to facilitate a useful goal development and accomplishment process in offenders that contributes to positive changes in them. The offenders are participants who actively participate in pursuing their goals, which brings beneficial changes to their lives.

The structure of solution-focused group treatment with domestic violence offenders is guided by the following principles.

FIGURE 1. A solution-focused frame of change versus that of feminist-cognitive-behavioral perspectives.



A Focus on Solutions and Strengths

Instead of discussing or exploring clients' problems with violence or their deficiencies, the focus is on the successes of participants in dealing with their problems of violence and how to notice and use them more often (Lee, Greene, & Rheinscheld, 1999). Focusing on solutions is neither a consequence of naive beliefs regarding strengths in participants nor simplistic positive thinking. The focus on solution talk to achieve change is supported by a systems perspective (Bateson, 1979). One basic assumption of a systems perspective is that change is constant. Every problem pattern includes some sort of exception to the rule (de Shazer, 1985). Despite the many deficiencies and/or problems participants may perceive that they have, there are always times when they handle their life situations in a more satisfying way or in a different manner; there must be times when they are not aggressive or violent and use other means to resolve conflicts and differences with people (Lee et al., 1999). These exceptions provide the clues for solutions (de Shazer, 1985) and represent the participant's unnoticed strengths and resources that can be used to address the problem of violence. The task for the therapist is to assist participants in noticing, amplifying, sustaining, and reinforcing these exceptions, regardless of how small and/or infrequent they may be (Berg & Kelly, 2000).

Utilizing Language of Strengths and Successes

Influenced by social constructivism, solution-focused therapists view language as the medium through which personal meaning and understanding are expressed and socially constructed in conversation (de Shazer, 1994). Furthermore, the meaning of things is always contingent on the contexts and the language within which it is described, categorized, and constructed by participants (Wittgenstein, 1958). Because the limits of reality that can be known and experienced by an individual are framed by the language available to him or her to describe it and these meanings are inherently unstable and shifting, a major therapeutic challenge for solution-focused therapists is to initiate a conversation of change that assists participants in constructing meanings and solutions by helping them to describe goals, to observe behaviors, and to carry on progressive lives in new and beneficial ways (Miller, 1997). In our program, we do not drill on the participants' problem with violence nor its history because pathology and problem talk may sustain a problem reality through implementing self-fulfilling prophecies, which further disempowers participants and distracts group participants' and our attention from developing solutions (de Shazer, 1994; Miller, 1997).

Accountability for Solutions

Not focusing on participants' responsibility for problems and/or deficits is just a decisive way for treatment providers to direct all therapeutic energy toward supporting offenders' responsibility for building solutions. In this program, the solution is established in the form of a goal that is to be

determined and attained by individual participants. Participants are required to develop a goal by the third session and to report on their goal efforts every session. They are held accountable for goal accomplishment that requires hard work, discipline, and effort (Berg & Kelly, 2000).

Participants Define Their Goals and Construct Their Solutions

Influenced by social constructivism, solution-focused facilitators view solutions as private, local, meaning-making activities by individual participants (Miller, 1997). In working with domestic violence offenders, the facilitator refrains from suggesting goals or making assumptions regarding the appropriateness or helpfulness of individuals' goals. Therapeutic dialogues focus on a range of evaluative questions that assist participants in self-evaluating the usefulness, appropriateness, and feasibility of their goals in their personal lives.

Present and Future Orientation

In order to hold domestic violence offenders accountable for their solutions, facilitators focus on assisting them in their present and future adjustment. The solution-focused facilitator asks questions that help participants to describe a future that does not contain the problem and to identify the first small step they can take to attain a future without the problem (De Jong & Berg, 2002).

A Collaborative Therapeutic Relationship

A constructivist view of solutions perceives participants as the knowers and experts regarding their individual experiences, realities, and aspirations (Cantwell & Holmes, 1994) who determine and achieve goals that will lead to a life that does not contain violence. The facilitator takes the role of an expert in constructing a dialogue with each participant that focuses on change and solution. The resulting relationship is egalitarian and collaborative instead of hierarchical. Such a collaborative relationship also engages participants and enhances their motivation to accomplish positive changes in their lives (Lee et al., 1999; Murphy & Baxter, 1997).

Utilization: A Noninstructional/Educational Approach

Utilizing and building on participants' strengths and exceptions is a more efficient and effective way for them to develop solutions that are relevant to and viable in their unique life circumstances. The task for the facilitator is to elicit, trigger, reinforce, expand, and consolidate exceptions the participant generates (Berg, 1994). The facilitator stays away from teaching participants skills or intervening in their lives in ways that may fit the facilitator's model of what is good but that may not be appropriate or viable in participants' lives.

In sum, a solution-focused approach holds the domestic violence offenders accountable for building solutions rather than focusing on their problems and deficits. The move away from a skill-deficit approach is underscored by a systems perspective (Bateson, 1979) as well as the role of language in creating and sustaining reality (de Shazer, 1994; Wittgenstein, 1958).

The focus on constructing solutions, respecting clients' self-determined goals, and utilizing clients' strengths and expertise leads to a fundamental change in the therapist–client relationship from being hierarchical to being collaborative. Solution-focused facilitators believe that it is their central moral and ethical responsibility to respect the victims and the offenders by developing and using therapeutic techniques that effectively and quickly create changes in the offenders' lives, which include the cessation of violence in intimate relationships.

The Outcome Study

Method

The study used a one-group pre- and posttest design with a 6-month follow-up to evaluate the effectiveness of the treatment program on the basis of multiple reporting sources that included program participants, their partners or spouses, and official arrest records. The study was collaboration between field practitioners and a researcher from an academic institution; our goal was to evaluate the effectiveness of a solution-focused approach for treating domestic violence offenders. The study explored the following research questions: (a) How did the behaviors of program participants in a relational context change following program completion as evaluated by their partners or spouses? (b) How did participants' self-assessment of their self-esteem change following program completion? (c) What were the recidivism rates of program participants based on arrest records and self-reports of participants and their partners or spouses? (d) What were the program completion rates of those participants who were admitted to the program? (e) What were the relationships between participants' profiles and recidivism rates based on official arrest records?

Research participants. Study participants were male or female domestic violence offenders who were ordered into treatment by the court and offered the opportunity to avoid prosecution by completing the group treatment program and abstaining from further violent conduct. Some of them pleaded guilty and were ordered by the court to attend the program. The spouses and partners of program participants were also included in evaluating the program's effectiveness. The intake staff asked participants for their formal written consent regarding participation in the program evaluation as well as their consent to contact their partners or spouses. No incentives were offered to participants. One member of the research team contacted the spouses and partners of participants to obtain separate consent from them. It was made clear to program participants and their spouses or partners that participation in the study was voluntary, information would be kept confidential, and their decision regarding participation would not affect the treatment the offenders received. In addition, to protect spouses and partners from potential negative couple dynamics and to maintain anonymity of their participation, the following measures were taken: (a) Only plain white envelopes were used in the mailing process with spouses and partners, and (b) when

TABLE 1. Demographic Information on Program Participants (*N* = 90)

DEMOGRAPHIC	%
Gender	
Male	85.6
Female	14.4
Ethnicity	
White Americans	84.1
African Americans	10.2
Native Americans	3.4
Hispanic Americans	2.3
Age	
20 or less	3.3
21–30	16.7
31–40	44.4
41–50	30.0
51 and above	5.6
Years of education	
< High school	12.6
High school	49.4
College	36.7
Graduate and above	1.3
Occupation	
Unemployed	20.2
Laborers	55.1
Professionals/technicians	7.9
Service	6.7
Students	5.6
Welfare/disability	2.2
Own business	1.1
Homemakers	1.1
Marital status	
Single	11.1
Married	46.7
Divorced or separated	42.2

conducting the 6-month follow-up interview with spouses and partners, interviewers were instructed not to disclose their identity if the call was not answered by the spouses or partners. Also, interviewers routinely asked the spouses and partners whether the time was a good time for them to be interviewed and would set up another time as indicated by the spouses or partners if they did not feel comfortable being interviewed at the time of the call.

Program participants. Data analyses were based on data of participants of 14 groups that were conducted between October 1996 and January 2002. Respondents consisted of 90 program participants: 77 men (85.6%) and 13 women (14.4%). The age of the program participants ranged from 19 to 61 years ($M = 37.2$, $SD = 9.0$). Program participants were predominantly Caucasian (84.1%), with 10.2 % African Americans, 3.4% Native Americans, and 2.3% Hispanic Americans. Participants had attained an average of 12.6 years of education ($SD = 1.5$, range = 9–19). Regarding the marital status of program participants, 46.7% were currently married or lived with a partner, 42.2% were divorced or separated, and 11.1% had never married. Over half of the participants self-identified as laborers (55.1%), 7.9% were professionals, 6.7% were service workers, 5.6% were students, 2.2% were on welfare or disability, 1.1% owned a business, 1.1% were homemakers, and 20.2% were unemployed.

TABLE 2. *DSM-IV Diagnoses of Program Participants (N = 90)*

DIAGNOSIS	%
Axis I	
No diagnosis	81.1
Intermittent explosive disorder	6.7
Major depression	2.2
Schizoaffective disorder	2.2
Impulse control disorder	2.2
Posttraumatic stress disorder	2.2
Bipolar disorder	1.1
Attention deficit hyperactive disorder	1.1
Adjustment disorder	1.1
Axis II	
No diagnosis	74.4
Antisocial personality disorder	20.0
Dependent personality disorder	2.2
Narcissistic personality disorder	1.1
Obsessive-compulsive personality disorder	1.1
Personality disorder NOS	1.1
Axis III	
No diagnosis	88.8
Brain injury	4.5
Other medical conditions	6.7

Global assessment functioning: $M = 61.6$ ($SD = 4.1$), range: 50–74

Note. *DSM-IV* = *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994); NOS = Not Otherwise Specified

A mental status examination was conducted at intake by an experienced, licensed clinical social worker. The information regarding diagnoses was collected not for treatment purposes but mainly for research and administrative purposes. Using *DSM-IV* criteria, we found that 18.8% of the program participants had an Axis I diagnosis, and 25.5% had personality characteristics that suggested an Axis II diagnosis of personality disorder. The Global Assessment Function scores of participants ranged from 50 to 74 ($M = 61.6$, $SD = 4.1$), meaning that an average program participant was able to function in social, occupational, or school settings with only mild symptoms.

We also collected information about the participants regarding their involvement in criminal offenses and childhood experiences. Of the 90 participants, 61.4% had substance and/or alcohol abuse problems, and 23.3% had involvement with criminal offenses other than domestic violence. In addition, 39.5% of program participants had experienced parental divorce or separation, 56.9% were children of alcoholics, and 44.3% had experienced abuse as children. This profile is consistent with what is being suggested by existing literature regarding characteristics of domestic violence offenders, in that a sizable number of offenders have problems with substance abuse and/or experienced abuse as children.

Spouses and partners of participants. Forty spouses and partners of participants consented to participate in the study and completed the questionnaires before the group treatment program. Such a response rate from was favorable since only 46.7% of participants were married or lived with a partner during the time of the study. Of these 40 respondents, 34 (85%) completed the questionnaires at termination, and 22 (55%) were successfully contacted during the 6-month follow-up telephone interview.

Methods of data collection. Self-assessment of participants' self-esteem and partners' and spouses' evaluation of participants' relational behaviors in intimate relationships were obtained at intake prior to the beginning of treatment, at termination following the last group session, and at 6-month follow-up. The research team member at the university or her research assistants conducted the 6-month follow-up telephone interviews during which participants' and their partners' or spouses' evaluation of the program and levels of violence in their intimate relationships were also collected. The following instruments were administered.

Index of Self-Esteem (ISE). This is a 25-item scale developed by Hudson (1992) to measure the degree, severity, or magnitude of a problem the client has with self-esteem. This instrument was completed by each program participant who was asked to rate the statements on a 1 to 7 scale. Some examples of the statements are "I feel ugly" and "I feel that people really like to talk with me." The scores of the ISE range from 0 to 100, with higher scores indicating lower self-esteem. The scale has two cutting scores. Scores below 30 (± 5) indicate the absence of clinically significant problems related to self-esteem issues. Scores above 70, on the other hand, indicate that respondents have significant problems related to self-esteem issues. The ISE has good reliability and validity (Hudson, 1992). In this study, the scale obtained a satisfactory reliability coefficient of .92 (Cronbach's alpha).

Solution Identification Scale (SIS). Inspired by the SIS developed by Ron Kral at the Milwaukee Brief Family Therapy Center and the Solution Recovery Scale for Survivors of Sexual Abuse developed by Yvonne Dolan (1991), Jeffrey Goldman and Mary Baydanan at Peaceful Alternatives in the Home developed a 30-item scale to assess couples' solution-oriented relational behaviors (Goldman & Baydanan, 1990). This instrument was completed by partners and spouses who were asked to rate the statements on a 1 (*never*) to 10 (*always*) scale. Some examples of the statements are "cooperates with partner/spouse," "expresses feeling other than anger," and "supports spouse's or partner's friendships." The scores of the SIS ranged from 30 to 300, with higher scores indicating better relational skills in intimate relationships. The instrument was originally developed for therapeutic purposes in couple therapy (sometimes with couples who have been involved in spousal violence). As such, no reliability and validity tests have been reported. On the other hand, this instrument is based on a solution-focused orientation—a philosophy that is consistent with the practice orientation of this group. In this study, the scale obtained a highly satisfactory reliability coefficient of .93 (Cronbach's alpha).

Recidivism rates. The recidivism rate measured the rate of participants' recommitting violent behaviors after attending the treatment program. We collected the cumulative recidivism rate of participants, meaning that we collected data on reoffending after participants completed the program and did not limit it to a 6-month period. Data on recidivism were collected from the victim witness office, the probation office, and the district attorney's office. Definitions of recidivism by

each source were different because of the difference in the function of each institution and the reporting venue. For instance, the district attorney's office documented cases of domestic violence that were reported and charged. The victim witness office documented cases of domestic violence whenever a victim was referred for service, regardless of whether a charge was pressed against the offender or whether there was a request for a restraining order. This study used more inclusive criteria that defined recidivism as (a) a participant was arrested for charges related to domestic violence, (b) a domestic violence charge was pressed against a participant, (c) the spouse or partner of a participant was referred to receive services from the victim witness office, or (d) there was a request for a restraining order against a participant.

Reports from participants and their partners or spouses regarding participants' physical and/or verbal abusive behaviors in intimate relationships were collected in the telephone interviews conducted by independent interviewers 6 months after termination of the group. Participants and their spouses and partners were asked to rate on a scale of 0 to 10 the level of violence before the participants participated in the treatment program and the current level of violence in intimate relationships. Participants and their spouses and partners were asked to specify the incidents whenever abusive behaviors were reported. Information on verbal abusive behaviors was also collected because of the potential of ongoing intimidation in relationships despite cessation of physical violence (Saunders, 1995).

Program completion rate. Program completion rate measured the percentage of program participants who successfully completed the treatment program. It was calculated by comparing the number of participants who enrolled in the program and attended the first group meeting and the number of participants who attended at least seven out of eight group sessions.

The selection of instruments was guided by previous research, as well as a theoretical orientation of a solution-focused, strengths-based approach for treatment of domestic violence offenders. Previous literature identified recidivism rates as relevant and valid measures of the treatment effectiveness of programs for domestic violence offenders (Saunders, 1996; Shepard, 1992), and program completion has been a significant factor to consider because it is indicative of treatment compliance and treatment-client congruence (Cadsky et al., 1996). We obtained data regarding

cessation of violence in offenders primarily using recidivism rates based on official arrest records and self-reports of participants' spouses or partners at the 6-month follow-up interviews. The study measured positive changes in domestic violence offenders as a consequence of the treatment, a method that is consistent with a solution-focused treatment orientation. The ISE was used to examine changes in offenders' self-assessment of their self-esteem. Although low self-esteem is a risk marker for domestic violence (Straus, 1996), self-esteem is not an established measure of treatment effectiveness. Instead, self-esteem measures were more commonly used in studies that examined treatment compliance and program attrition. Participants with a more negative evaluation of themselves were more likely to attend the program, but they were no more likely to complete it (Cadsky et al., 1996; Chang & Saunders, 2002). This study used self-esteem as an outcome measure on the basis of theoretical assumptions of a solution-focused perspective that postulates positive accomplishment of a personally meaningful goal will be associated with a positive perception of self. The SIS was used to measure positive changes in offenders' relational behaviors in intimate relationships as perceived by their partners and spouses. The focus of investigation of both instruments was consistent with the solution-focused and strengths-based orientation of such a treatment approach.

Two instruments that had been widely used in previous prominent studies regarding treatment for domestic violence offenders were the Conflict Tactic Scale developed by Straus and Gelles (1990) and the Abusive Behavior Inventory (Shepard & Campbell, 1992). Both instruments were used to examine the levels of violence in intimate relationships. These two instruments were not included in the present study because of the underlying philosophical differences between the problem-focused nature of these instruments and a solution-focused approach for treatment. Instead, data of recidivism rates based on official records and self-reports of participants and their spouses or partners regarding current levels of verbal and physical violence would provide adequate, if not the best, measurement of the levels of violence in intimate relationships.

Methods of data analysis. Data collected from the various instruments were checked and coded for data processing and statistical analyses. The Statistical Package for Social Sciences

TABLE 3. Paired-Sample *t* Tests for Comparing Mean Scores of the Index of Self-Esteem (ISE) and the Solution Identification Scale (SIS) at Pretreatment, Termination, and 6-Month Follow-Up

INSTRUMENT	PRETREATMENT		TERMINATION		<i>t</i>	<i>df</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
ISE ^a (<i>n</i> = 82)	24.5	12.8	22.4	11.2	-2.2	81	< .05
SIS (<i>n</i> = 34)	197.9	64.7	236.8	40.3	3.6	33	< .001
	PRETREATMENT		6-MONTH FOLLOW-UP				
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
ISE (<i>n</i> = 48)	26.8	14.1	21.2	12.4	-3.1	47	< .01
SIS (<i>n</i> = 22)	192.0	55.3	236.5	37.7	4.1	21	< .001

^a For the ISE, a higher self-esteem score indicates more problems with self-esteem.

Note. Number of respondents who provided data for pretreatment and termination is different from the number of respondents who provided data for pretreatment and 6-month follow up.

TABLE 4. *Recidivism Reports*

SOURCE OF REPORT	RECIDIVISM RATE	
	%	Number
Official records (<i>n</i> = 90)		
District attorney (DA)	6.7	6
Probation office (PO)	4.4	4
Victim witness (VW)	15.5	14
DA, PO, or VW	16.7	15
Spouses/partners' reports (<i>n</i> = 22)	13.5	3
Program participants' reports (<i>n</i> = 47)	2.1	1

was used for this purpose. A series of paired-sample *t* tests were used to compare the pre- and postmeasures of the various assessment instruments that were completed by program participants and their spouses or partners.

Findings

ISE. Program participants completed the ISE at pretreatment, termination, and 6-month follow-up. Among the 90 program participants, 87 completed the questionnaire at pretreatment. Of these 87 participants, 82 participants completed the ISE at termination (94.3%), and 48 did so at the 6-month follow-up telephone interview (55.2%). Eighty-two participants completed the ISE at both pretreatment and termination. The ISE mean score of 22.4 (*SD* = 11.2) at termination compared favorably with the mean score of 24.5 (*SD* = 12.8) at pretreatment. Paired-sample *t* tests comparing the pretreatment and posttreatment outcomes indicated a significant improvement in participants' self-evaluation of their self-esteem: $t(81) = -2.2, p < .05$.

Forty-eight participants were contacted 6 months after they had completed the treatment program. Among those whom we could not contact at the follow-up phone interviews, 3 had no telephones, 25 had their telephone line disconnected, 2 no longer lived at the same residence, 3 refused to respond to the

interview despite earlier consent, and 9 could not be contacted despite repeated attempts. Questionnaires were also mailed to those whom we could not contact. Findings of the study indicated that the ISE mean score of 21.2 (*SD* = 12.4) at 6-month follow-up compared favorably with the mean score of 26.8 (*SD* = 14.1) at pretreatment. A paired-sample *t* test comparing the pretreatment and 6-month follow-up outcomes indicated a significant improvement in participants' self-reports of their self-esteem: $t(47) = -3.1, p < .01$.

SIS. Reports based on the responses of spouses and partners of program participants indicated a significant improvement in the participants' relational skills in intimate relationship since their participation in the program. The SIS mean score of 236.8 (*SD* = 40.3) at posttreatment compared favorably with the mean score of 197.9 (*SD* = 64.7) at pretreatment. Findings from a paired-sample *t* test showed that there was a significant increase of SIS scores from pretreatment to posttreatment based on the evaluation of the spouses and partners of program participants indicating better relational behaviors of program participants in intimate relationships: $t(33) = 3.6, p < .001$.

Twenty-two spouses and partners responded to the 6-month follow-up phone interviews. The SIS mean score of 236.5 (*SD* = 37.7) at the 6-month follow-up compared favorably with the mean score of 192 (*SD* = 55.3) at pretreatment. Findings from a paired-sample *t* test showed that there was a significant increase in SIS scores from pretreatment to follow-up, indicating a significant improvement of program participants' relational behaviors in intimate relationships based on the evaluation of their spouses or partners: $t(21) = 4.1, p < .001$.

Recidivism rates. Data on recidivism rates of program participants based on official records were collected from the victim witness office, the probation office, and the district attorney's office. Data from the district attorney's office indicated a recidivism rate of 6.7% (*n* = 6), the probation office 4.4% (*n* = 4), and the victim witness office 15.5% (*n* = 14). Recidivism rates reported by each source were different because of the difference in the function of each institution and the reporting venues. Using more inclusive criteria, an overall recidivism rate of 16.7% (*n* = 15) was compiled by counting all reoffending cases that were reported by the victim witness office, the probation office, or the district attorney's office.

No significant differences in recidivism rates were found between genders. Specifically, 16.9% of male participants and 15.4% of female participants had reoffending records at the victim witness office, the probation office, and/or the district attorney's office.

At the 6-month follow-up interview, program participants and their spouses and partners were asked to rate on a scale of 0 to 10 the level of violence before the participants participated in the treatment program and the current level of violence in intimate relationships. Respondents were asked to evaluate both physical violence and verbal abuse in intimate relationships. Findings indicated a significant decrease in the participants' violent behaviors as perceived by the program participants and

TABLE 5. *Recidivism Reports by Program Participants at 6-Month Follow-Up (*n* = 47)*

SELF-REPORTED LEVEL OF VIOLENCE ON A 0–10 SCALE	PRETREATMENT		6-MONTH FOLLOW-UP	
	%	<i>n</i>	%	<i>n</i>
0	2.1	1	97.9	46
1	21.3	10	0.0	
2	8.5	4	2.1	1
3	2.1	1	0.0	
4	8.5	4	0.0	
5	21.3	10	0.0	
6	4.3	2	0.0	
7	17.0	8	0.0	
8	10.6	5	0.0	
9	2.1	1	0.0	
10	2.1	1	0.0	
<i>M</i>	4.6		0.0	
<i>SD</i>	2.7		0.3	
Range	0–10		0–2	

Note. Paired-sample *t* tests comparing means of self-reported level of violence between pretreatment and 6-month follow-up: $t(46) = 11.3, p < .001$.

TABLE 6. Recidivism Reports by Spouses/Partners of Program Participants at 6-Month Follow-Up ($n = 22$)

SELF-REPORTED LEVEL OF VIOLENCE ON A 0–10 SCALE BY SPOUSES/PARTNERS	PRETREATMENT		6-MONTH FOLLOW-UP	
	%	<i>n</i>	%	<i>n</i>
0	0.0	0	86.4	19
1	22.7	5	4.5	1
2	4.5	1	4.5	1
3	13.6	3	4.5	1
4	13.6	3	0.0	
5	4.5	1	0.0	
6	4.5	1	0.0	
7	4.5	1	0.0	
8	9.1	2	0.0	
9	9.1	2	0.0	
10	13.6	3	0.0	
<i>M</i>	5.0		0.3	
<i>SD</i>	3.3		0.8	
Range	1–10		0–3	

Note. Paired-sample *t* tests comparing means of reported level of violence of program participants by spouses/partners between pretreatment and 6-month follow-up: $t(21) = 6.7, p < .001$.

their spouses and partners. Of the 47 program participants who responded to the question during the follow-up interviews, all except 1 participant reported committing some sort of violence in intimate relationships prior to receiving treatment. Only 1 man reported committing a low level of violence (2) in his current relationship.

The perceived level of violence decreased significantly from 4.6 ($SD = 2.7$) at pretreatment to 0 ($SD = 0.3$) at the 6-month follow-up: $t(46) = 11.3, p < .001$. This perception of improvement was shared by participants' spouses or partners. Of the 22 spouses and partners who responded to this question during the follow-up interviews, only 3 (13.5%) reported their spouses committing a low level of violence against them (a score of 1, 2, and 3, respectively). The perceived level of violence decreased significantly from a mean score of 5 at pretreatment ($SD = 3.3$, range = 1 to 10) to 0.3 ($SD = 0.8$, range = 0 to 3) at the 6-month follow-up: $t(21) = 6.7, p < .001$.

Program completion rate. Between October 1996 and January 2002, a total of 97 persons were accepted into the program and attended the first session of the group. Among the 97 persons, 90 completed the program. The completion rate is 92.8%. Of the 7 noncompleters, 3 attended a later group and successfully completed the program.

Participants' profiles and recidivism. We also examined the relationship between participants' profiles and recidivism as based on official arrest records. Findings indicated that having a *DSM-IV* Axis I psychiatric disorders or Axis II diagnosis of personality disorders was not related to recidivism. In addition, participants' recidivism was not related to substance and/or alcohol abuse problems, involvement with criminal offenses other than domestic violence, experience of parental divorce, or coming from a family with a history of parental alcoholism. Findings from chi-square analyses, however, indicated that participants' self-reports of experiencing abuse as a child had a signifi-

cant association with recidivism as based on official arrest records: $\chi^2(1, N = 79) = 5.4, p < .05$.

Discussion

In this study, we used multiple reporting sources in the evaluation process. The use of strengths-based instruments also expanded the conventional evaluation focus of behavioral change in terms of cessation of violence to include positive changes or learning in relational behaviors in intimate relationships. Findings of the study provided initial empirical evidence of the effectiveness of a solution-focused approach for treating domestic violence offenders. Using official arrest records and including all reoffending cases that were reported by the victim witness office, the probation office, and the district attorney's office, we found that the recidivism rate of 16.7% for this program was considerably lower than that for most other conventional treatment programs. This recidivism rate, which was based on official arrest records, was comparable to the recidivism rate of 13.5% reported by spouses and partners at the 6-month follow-up interviews. In addition, participants and their spouses and partners perceived a significant decrease in participants' verbal and physical violent behavior 6 months after participants' completion of the program. On the other hand, there were huge differences in the recidivism rates that were based on official records and in rates that were based on spouses' or partners' reports compared with rates that were based on and participants' self-reports (2%). Such a finding, however, is consistent with existing literature that documents the problem of underreporting among offenders, making them an unreliable source of recidivism reports (Heckert & Gondolf, 2000).

The program completion rate of 92.8% was impressive compared with rates for most other batterer treatment programs based on feminist-cognitive-behavioral or process-psychodynamic approaches, including short-term programs whose program completion rate is approximately 60% (Cadsky et al., 1996; Chang & Saunders, 2002; DeMaris, 1989; Edleson & Syers, 1990). Although the number of sessions for our program (8 sessions) is comparable to other short-term programs (10–12 sessions), the length of each session of our program is an hour, which is significantly shorter than the session length of other short-term programs, which is usually 2.5 hours. Besides the possible benefits of the short duration of our program and the clear group rule regarding attendance that was set early on in the treatment process, we believe the high program completion rate can be attributed to client-treatment congruence (Cadsky et al., 1996; Wierzbicki & Pekarik, 1993). A solution-focused approach for treating domestic violence offenders focuses on helping participants to develop and accomplish personally meaningful goals that are interpersonally related. Because participants selected and determined their personal goals, they were more likely to perceive the treatment as beneficial and personally meaningful, which probably increased their motivation to complete the program.

Among program participants who were involved in intimate relationships, which was around half of the original

sample, findings indicated a significant improvement in their relational skills in intimate relationships as evaluated by their spouses and partners. The improvement in participants' relational skills from pretreatment to posttreatment was maintained 6 months after completion of the program. Based on self-reports of participants, the findings indicated a significant increase in their self-esteem from pretreatment to posttreatment. The increase in participants' self-esteem was maintained 6 months after their completion of the treatment program. The positive changes in participants' self-assessment are consistent with the theoretical assumption of a solution-focused approach that postulates positive accomplishment of a personally meaningful goal will be associated with a positive perception of self. Positive changes in self-esteem have not been established as valid outcome measures for treatment effectiveness, although low self-esteem is a risk marker for domestic violence. Future studies will need to be conducted to further explore the utility of this measure as an outcome measure. In addition, participants' recidivism as based on official arrest records was only related to experiencing abuse as a child but not to other profiles, including psychiatric diagnoses, substance and/or alcohol abuse problems, involvement with criminal offenses, experience of parental divorce, or coming from a family with a history of parental alcoholism.

The outcome study had difficulties, resource constraints, and limitations shared by other studies. The major limitations were modest sample size, lack of a control or comparison group, and lack of control of external factors such as divorce, relocation, or incarceration that might influence the outcome. In addition, the response rates of participants and their partners and spouses at follow-up interviews were both around 55%. The considerably higher response rates of our study as compared with some other studies of batterer programs do not reduce the problem of selectivity bias in the follow-up study. Participants who improved or had a positive perception of the program might have a higher response rate than those who did not improve or approve of the program. To find out whether there were significant differences between the group of program participants that responded to the follow-up interviews and the group that did not respond, we conducted further analyses to compare the two groups on recidivism rates based on official arrest records, relevant demographic variables (race, education, age, employment, gender), and other background variables (*DSM-IV* Axis I and Axis II diagnoses, alcohol and/or substance abuse, parental divorce, family alcoholism, criminal offenses, and experience of abuse as children). Findings from chi-squares

did not indicate significant differences between the two groups on any one of these variables. In other words, there is a lack of empirical evidence for selectivity bias between the group that responded and the group that did not respond at the 6-month follow-up interviews.

Recidivism rates reported by participants and their spouses had to be interpreted with caution. As mentioned earlier, the response rates of participants and their spouses at the 6-month follow-up were around 55%. Despite the lack of evidence for selectivity bias, we still did not have complete data on all participants and their spouses at the 6-month follow-up. In addition, only 46.7% of participants were in intimate relationships at the time of evaluation. On the other hand, data on recidivism rates based on official arrest records were collected for all program participants. Still, we had concerns about the validity of those recidivism rates because some participants might have moved out of the state after completing the program. Consequently, the recidivism rates compiled from official records may not have reflected the actual occurrence of violent behaviors by

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the offenders. This problem is common to all outcome studies of batterer programs. Attempts were made to find out whether participants whose telephone lines had been disconnected or those who could not be contacted at the 6-month follow-up were represented in the reoffending group as based on official arrest records. Findings indicated that participants whose telephone lines had been disconnected or those who could not be contacted were represented in the reoffending group. Among the 42 participants we failed to contact during the follow-up interview, 10 had reoffending records at the victim witness office, the probation

office, and/or the district attorney's office. Although such information did not constitute valid proof of local residence of participants, it did imply that some of the participants we failed to interview during the 6-month period still resided within the local judicial system.

Another limitation of the present study is the use of self-reports, which is related to the problem of reporting bias. Such a problem is illustrated by the differences in recidivism rates reported by program participants, in the recidivism rates reported by their spouses or partners, and in the recidivism rates based on official records. On the other hand, self-report is a valid and commonly used method to examine respondents' construction of their experience. To partially address the problem of reporting bias, especially by offenders who are more likely to minimize or underreport their problems (Edleson & Brygger, 1986; Heckert & Gondolf, 2000; Yllo, 1988), we used multiple reporting sources and only asked

offenders to self-assess changes in their self-esteem, which is a more private, intrapersonal construct. We evaluated the changes in participants' relational behaviors in intimate relationships using the reports of their spouses or partners. We reported the participants' recidivism rates using official arrest records and reports of participants' spouses or partners.

Attribution bias was not addressed in this study because of the small number of offenders who did not complete the program. Among the 97 persons who were accepted into the program and attended the first session of the group, only 7 did not complete the program. Of the 7 noncompleters, 3 attended a later group and successfully completed the program.

Conclusion

There is much diversity in how the problem of domestic violence should be approached. Helping professionals are constantly in search of effective ways to provide treatment for domestic violence offenders, although such a search is haunted by hope, promises, and controversies. Current treatment programs for domestic violence offenders have been dominated by a deficits perspective, probably as a result of the existing understanding of the etiology of domestic violence as well as the assumption that domestic violence offenders need to be reeducated and punished for their behaviors. Despite our strong belief in the concerted efforts of different systems used in combating domestic violence, the efforts of different systems should be coordinated but not confused. Systems that are immediately involved include but are not limited to law enforcement, probation departments, district attorneys, judges, treatment providers, health care professionals, and women's shelters. Each system has its own mandate and purpose. There should be a clear separation of responsibilities for punishment, for legal decision-making, and for facilitation of change. Confusion of responsibilities is problematic for both the offenders and treatment providers. Relevant to treatment providers is the separation of social control and treatment function in programs. A solution-focused approach avoids taking a social control function that focuses on holding offenders responsible for their problems and teaching them what is right or wrong. Treatment cannot effectively serve a social control function for the simple reason that therapists are not legitimized by society to punish and control people. Therapists or group facilitators are professionally trained to assist people in a self-initiated process of change.

The benefits of using a solution-focused approach that separates punishment from treatment include the following: (a)

The program completion rate of 92.8% was impressive compared with rates for most other batterer treatment programs.

It is easier for a group facilitator to engage in and develop a meaningful working relationship with program participants as the facilitator does not play a role in determining who gets what punishment but simply provides treatment to the participant who is mandated or required by the courts to receive treatment. (b) It is more likely that participants will talk about issues they feel are relevant to changes that they need to make, rather than simply wanting to present a positive image so that they can get the court off their back. (c) Program facilitators are relieved from the dilemma of having to provide treatment and at the same time be a social control agent. In addition, because solutions or goals are constructed by participants and there are exceptions to all problem patterns (de Shazer, 1985), our program does not exclude participants on the basis of *DSM-IV* diagnoses or substance use, as we believe offenders have abilities to accomplish self-determined, personally meaningful goals. On the other hand, there are clinical challenges presented by using such an approach. Holding offenders accountable for solutions requires hard work. A major challenge is for program facilitators to help offenders develop a useful, personally meaningful goal early on in the treatment process. It is imperative for facilitators and participants to stay focused on solutions and not to be distracted throughout the process. Sometimes, solution-focused facilitators are challenged to respect offenders' strengths and abilities more than offenders themselves (Lee et al., 2003b).

A solution-focused approach uses the language and symbols of solution and strengths for treating domestic violence offenders. The use of the language and symbols of solution and strengths for treating domestic violence offenders is not without controversy. A solution-focused approach is not a panacea for the treatment of domestic violence offenders. Instead, it is part of the pluralistic, societal effort to develop pragmatic solutions to end the more immediate, visible violence in intimate relationships. Diversity and multiple voices are imperative in the search for effective treatments for domestic violence offenders. A single voice or a single vision can only replicate the dynamic of dominance in abusive relationships. While searching for treatments, it is important to evaluate the effectiveness of a particular treatment program and carefully examine the associated mechanisms and processes that contribute to its effectiveness so that treatment is based on an informed position in addition to ethical choices or ideological preferences (Gingerich & Eisengart, 2000).

Despite efforts to evaluate the effectiveness of batterer programs, Gondolf (1997) suggested, "in a social science court, most of the batterer program evaluations would be dismissed on technicalities or as circumstantial evidence" (p. 208). Such

scrutiny probably applies to this study. Despite the initial empirical evidence that indicates comparatively lower recidivism rates, higher program completion rates, and positive evaluation of participants' self-esteem and relational skills in intimate relationships based on feedback from participants and their spouses or partners, we cannot conclude in any decisive manner that a solution-focused approach is more effective than other treatment approaches because of a lack of comparison groups and the use of nonrandomized samples in the present study. Limitations of research methodology, on the other hand, present both challenges and opportunities for practitioners and researchers to further examine the effectiveness of treatment programs using a solution-focused approach in treating domestic violence offenders. In addition, there is a clear and unambiguous need to search for methodological rigor, a clear conceptualization of effectiveness, an expanded focus of evaluation, and the inclusion of a strengths perspective in the field of domestic violence treatment.

Specific recommendations for future investigations include (a) using control groups that include conventional treatment modalities such as feminist-cognitive-behavioral models or psychodynamic approaches; (b) using a larger sample for more precise and refined statistical analysis; (c) developing research sites that include urban and rural locations, higher and lower socioeconomic status communities, and localities with more ethnic and racial diversity; (d) developing strategies to improve response rates for follow-up interviews; (e) using multiple reporting sources; (f) developing strengths-oriented instruments and frameworks in the process of evaluation; and (g) expanding the focus of evaluation to include offenders' behaviors, the social impact on consumers, including the victims, and organizational components that contribute to positive outcomes. In addition, it is imperative to include qualitative methods in addition to quantitative methods in the process of evaluation. Qualitative methods can better assist researchers in understanding the subtle process of change in domestic violence offenders.

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